Insights

Acknowledging State Challenges in Medicaid Administration

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Earlier this year, the U.S. Government Accountability Office ("GAO") issued a Report to Congressional Requesters ("Report") recognizing state views on administration challenges with the Medicaid program. The audit informing the Report lasted nearly two years and was conducted in response to a request for the GAO to assess a range of federal Medicaid policies, specifically including the complexity and impact of federal Medicaid policies on states' ability to efficiently administer their programs.

According to the Report, of the state Medicaid officials interviewed from the 50 states and the District of Columbia, a majority of officials identified the following four program areas posing a significant or moderate challenge to the effective administration of the Medicaid program: (1) coverage exclusions and care coordination; (2) covered benefits and eligibility; (3) Medicare and Medicaid alignment; and (4) payment methods. Each program area is discussed further below.

1. **Coverage Exclusions and Care Coordination**

    a. Institution for Mental Diseases ("IMD") Exclusion. Officials reported the IMD exclusion, which prohibits federal payments for services provided to adult beneficiaries residing in IMDs, limits their ability to use Medicaid funds to provide beneficiaries with a full continuum of treatment and diverts beneficiaries to more expensive hospital settings. In addition, the 15-day monthly limit for managed care coverage is administratively burdensome.

    b. Social Determinants of Health. Officials reported the lack of coverage for health-related social services challenges states' efforts to lower costs and improve health outcomes, as well as causes individuals to access high-cost institutional settings.

    c. Data Sharing. Limitations on providers' ability to share substance use patient records was cited by officials as posing a barrier to care coordination.[1]

    d. Program Coordination. Officials reported limited or unclear authority to coordinate Medicaid funds with other funding, such as SNAP, as a barrier to coordinating services across programs.

    e. Department of Corrections. The limitation on coverage of Medicaid services for inmates of public institutions being held involuntarily was identified by officials as creating challenges in

ensuring care coordination.

2. **Covered Benefits and Eligibility**

    a. Prescription Drug Coverage Requirements. Officials identified difficulties in controlling costs and managing care due to prescription drug coverage requirements.

    b. Cost Sharing Limitations as Percent of Income. The limitation on states' ability to impose certain premium and cost-sharing requirements based on percent of income was identified as creating calculation difficulties.

    c. Home and Community-Based Services ("HCBS"). Officials cited the requirement for states that opt to cover HCBS under state plan authority to allow enrollment of all eligible individuals creates cost containment problems and incentivizes states to instead cover HCBS via waivers and demonstrations, which allow enrollment to be capped.

    d. Long-Term Services and Supports ("LTSS"). Officials noted the limitations on states' ability to tailor LTSS to certain populations under state plan authority increase the need for additional waivers and demonstrations.

    e. Medicaid Beneficiary Groups/ Aid Categories. The varying eligibility requirements between beneficiary groups are cited as being administratively challenging and confusing.

3. **Medicare and Medicaid Alignment**

    a. Lack of Alignment. While the Centers for Medicare & Medicaid Services ("CMS") has identified policy options for integrating administrative processes and payment between Medicare and Medicaid, officials noted that program coverage and payment differences limit integration efforts.

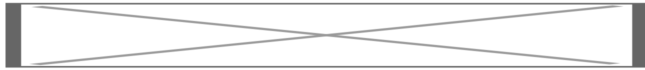
    b. Data Sharing. While CMS allows states to access Medicare data, officials still identified data sharing challenges, particularly with sharing data with Medicaid managed care plans.

    c. Unique Challenges for Dual Beneficiaries. Where a beneficiary is eligible for both Medicare and Medicaid, Medicare must pay for covered services before Medicaid, which officials noted creates additional burden and delays in accessing services.

4. **Payment Methods**

    a. Prospective Payment System Rate. Because states must generally pay federally qualified health centers ("FQHCs") and rural health centers ("RHCs") a prospective payment system rate based on historical costs (with certain adjustments), state officials identify concerns with providers switching to FQHC / RHC status to obtain potentially higher rates and limited payment reform efforts.

    b. Alternative Payment Methodology. While states can implement alternative payment methods to incentivize providers to improve quality and control costs, officials noted delayed guidance and lack of clarity on how such payment methods can be used, as well as the need to use



waiver authority to implement such payment methods.

State officials also reported challenges with obtaining federal approval of waivers (such as 1915(b), 1915(c), and 1115 waivers), including challenges with long delays, insufficient guidance, and increased administrative burdens. Officials also expressed concern about federal reporting requirements, which were described by some as overly burdensome, in part due to duplicative reporting requirements as well as uncertainty regarding whether such reporting was relevant or useful to CMS.

As part of the Report, CMS also had a chance to review and respond to the survey data. In general, CMS agreed with several of the challenges identified by State officials and noted areas where CMS has already taken action to reduce administrative burden and increase state flexibility, including:

- Implementing a state plan option to provide certain services to adults in an IMD;
- Providing technical assistance to state regarding housing services that may be covered under waivers and demonstration; and
- Streamlining waiver and demonstration processing.

In addition, the GAO also identified several interrelated considerations that apply broadly to any other efforts aiming to address the programmatic and administrative challenges identified by State officials.

Overall, this Report provides a thorough overview of how states are struggling to navigate the complex federal and state partnership in the administration of their Medicaid program. These administrative burdens are not only taxing on the limited time and resources of state employees, but also hamper state innovation and flexibility, which is particularly critical in light of the current challenges of the opioid epidemic and coronavirus pandemic. However, through the Report and subsequent open dialogue between the state and federal government, we anticipate that CMS will continue to address and alleviate the various challenges facing state officials through supporting state waiver development, adopting administrative rules, and making other policy changes.

For questions regarding State Medicaid administrative processes, this Report, or to discuss a government affairs strategy related to your unique Medicaid challenges and opportunities, please contact Meghan M. Linvill McNab.

[1] Note, on July 13, 2020, SAMHSA issued a final rule implementing changes to 42 CFR 2 to facilitate coordination of care by allowing patients to consent to the disclosure of records to an entity without the patient having to name a specific person and to consent to disclosure for payment and health care operations, among other revisions. Final Rule is available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-14675.pdf.